Rhode Island Department of Human Services
LTC Office Location_____

CASE MANAGEMENT ASSESSMENT

Office of Medical Review

SECTION I: REFERRAL

Assessment Date: _____ Referral Type: ___ Title XX ___ Initial
___ A&D Waiver ___ Re-Assess
___ Nursing Home ___ Disability
___ Other Determination

Location: ___ Home ___ NH ___ Other

DHS Social Worker: _____ Tel. No.: _____

SECTION II: CLIENT IDENTIFYING DATA

Name: _____DOB: _____ SSN:_____

Address: _____Apt#: ___ Floor:_____

City/Town: _____ Zip: _____ Telephone Number: _____

Primary Language: _____ Interpreter Needed: ___ Yes ___ No

Primary Contact Person: _____

Relationship _____ Contact Telephone Number _____

Address: _____ City/Town_____ State ____ Zip _____

SECTION III: LIVING ARRANGEMENTS

_____ Lives Alone _____Nursing Home _____Admission Date

_____Subsidized _____Group Home _____Admission Date

_____With Others _____ Residential/Assisted Living _____Admission Date

OMR: LOC

Diagnosis: _____ _____ _____

Approved: _____

To Be Re-evaluated _____ Date: _____

SECTION IV: FUNCTIONAL ABILITY

A. HOMEMAKING CAPABILITIES

YES	Limitations	NO	* Explain Limitations/Extra Needs
____	_____	____	Cleaning _____
____	_____	____	Laundry _____
____	_____	____	Shopping_____
____	_____	____	Meal Preparation_____

B. PHYSICAL FUNCTIONAL ABILITIES

Ambulation/Transfer

___ Alone
___ With Device
___ With Personal Assistance
___ Bed To Chair
___ Bed Only

Senses

___ Normal Sight
___ Failing Sight
___ Legally Blind

___ Normal Hearing
___ Impaired Hearing
___ Deafness

___ Normal Speech
___ Impaired Speech
___ Unable to Speak or Comprehend

Personal Requirements

___ Needs no help
___ Needs help bathing
___ Needs help dressing
___ Needs help feeding
___ Needs medication reminders
___ Needs others to give medications

Toileting

___ Tends to toilet functions alone
___ Tends to toilet functions with help
___ Occasionally Incontinent ___ Bowel ___Bladder
___ Chronically Incontinent ___ Bowel ___Bladder

Explain Additional Limitations: (include outside of home activities)

_____
_____
_____

Equipment/Assistive Devices:

_____
_____

C. MENTAL STATUS

___ Alert ___ Disoriented ___ Forgetful ___ Anxious
___ Confused ___ Depressed ___ Withdrawn ___ Agitated

Source of Information: _____
_____

SECTION V. RECOMMENDATIONS

Explain reason for recommendations, e.g. change in social and/or medical status, lack of community supports, etc.

Weekly Hours
Cleaning
Laundry
Shopping
Meals
Personal Care

____ Home Care (Title 20)
____ Home Care (Title 19 A & D Waiver)
____ Assisted Living Facility
____ Nursing Care Facility

Date **Signature**

SECTION VI: SUPPORTS

A. INFORMAL SUPPORTS (Family, Friends, etc.)

NAME	AGE	RELATIONSHIP	SPECIFIC TASK(S) PROVIDED

B. LONG TERM CARE/ADULT SERVICE SUPPORTS

Services	Providers	Frequency	Recommendations
Case Management			
CNA/Home Health Aide			
E.R.S.			
Homemaker			
Meals on Wheels			
Minor Asst. Devices			

C. HEALTH CARE PROVIDERS

Services	Providers	Frequency	Recommendations
Physician			
Mental Health			
Substance Abuse Tx			
Dental			
Nursing			
Rehab Therapies: (P.T./O.T./Sp)			
Medical Equipment			
Radiation/Chemotherapy			
Dialysis			
Other			

D. COMMUNITY SUPPORTS

Services	Providers	Frequency	Recommendations
Day Care			
Senior Center			
Senior Companion			
Meal Site			
Transportation			
Support Group			
Other			

DEPARTMENT OF HUMAN SERVICES
ELIGIBILITY ASSESSMENT: LEVEL OF CARE

NAME: Last_____ First_____ Med Asst#_____

DOB_____ Sex: _____ Male _____ Female

Name of Hospital:_____ DOA_____ DOD_____

Admitted From: Name of Facility:_____

Admitted From: Community Address:_____

Diagnoses: Primary_____

_____

Diagnoses: All Other:_____

Recommended Level of Care (Check one box):

_____NF (Medicare) _____ Nursing Facility _____ ICF/MR _____ Hospital

Waiver: _____DHS A&D _____MR/DD _____PARI _____DEA _____Asst Liv. _____Habil.

Duration_____ Denial_____

Katie Beckett_____ Duration_____

Specify Reasons for Recommended Level of Care (Include medical and nursing needs, functional and mental status):

Discharged to: Name of Facility:_____

Discharged to: Community Address:_____

Form completed by:_____ Date:_____
Signature

Physician sign here to certify patient likely to return home within six months:

_____ M.D.
signature

DEPARTMENT OF HUMAN SERVICES

HOME AND COMMUNITY-BASED CARE WAIVER

NOTIFICATION OF RECIPIENT CHOICE

RECIPIENT NAME:_____

ADDRESS: _____

CASE NUMBER: _____

Recipient Notification

I understand that I have been assessed and found to require the services provided in a Nursing Facility. I have been offered a choice between in-home community-based care and in-patient care in a Nursing Facility. I have chosen:

_____ **Placement in a Nursing Facility**

_____ **In-Home Community-Based Care which may include: Personal Care Services, Homemaker Services, LPN Services, Meals on Wheels, Senior Companion Services, Specialized Medical Equipment and supplies, Environmental Accessibility Adaptations, Emergency Response Services, and other Medical Assistance program covered services.**

Signature of Recipient or Representative **Date**

DEPARTMENT OF HUMAN SERVICES
INDIVIDUAL PLAN OF CARE

NAME:_____ DATE:_____

_____ CASE #_____

Service:_____ Service:_____

Provider:_____ Provider:_____

Frequency:_____ Frequency_____

Duration:_____ Duration:_____

Purpose:_____ Purpose:_____

Service:_____ Service:_____

Provider:_____ Provider:_____

Frequency:_____ Frequency_____

Duration:_____ Duration:_____

Purpose:_____ Purpose:_____

Service:_____ Service:_____

Provider:_____ Provider:_____

Frequency:_____ Frequency_____

Duration:_____ Duration:_____

Purpose:_____ Purpose:_____

Service:_____ Service:_____

Provider:_____ Provider:_____

Frequency:_____ Frequency_____

Duration:_____ Duration:_____

Purpose:_____ Purpose:_____

INSTRUCTIONS FOR COMPLETING DHS-121

This form is used by both the client and the agency representative to:

1. Identify in writing by the client the cause of his/her complaint or grievance; and
2. Identify by the agency representative the policy on which the decision causing the complaint was based.

This form is given to the client at the time s/he decides to appeal an agency decision.

For Food Stamps: A client has 90 days from the date of the Notice of Agency Action to request a hearing.

For All Other Programs: A client has 30 days from the date of the Notice to request a hearing.

Sections I and II

These two sections can be filled out by the client alone, or by the client and agency representative, if the client needs help in completing the form. The section is signed by the person making the complaint.

Section III

After Sections I and II are completed, the agency representative completes Section III, citing the agency policy(ies) with reference to the particular manual sections(s) that was the basis for making the decision. This section is signed by the agency representative and supervisor. The area identifying the area and district are completed. The form is routed promptly to the hearing office at Central Office.

NOTE: When the DHS-121 is completed by the client and mailed directly to Central Office, without being routed through the regional or district office, the hearing office makes a copy of the DHS-121. The original is sent to the regional or district office for completion of Section III. The DHS-121 must be returned to the hearing office at Central Office within seven (7) days.

Legal Help

At the scheduled hearing, you may represent yourself, or be represented by someone else such as a lawyer, a relative, a friend, or another person. If you want free legal help, call Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES **DHS-121**
REQUEST FOR A HEARING **Rev. 01/90**

SECTION I - IDENTIFYING INFORMATION

NAME _____
Recipient Category Case Number/Social Security Number

ADDRESS _____
Number and Street City/Town Zip

SECTION II -STATEMENT OF COMPLAINT (To be completed by applicant or recipient).

_____

_____

_____

_____

☐ **I wish to continue to receive** the amount of assistance and/or food stamps I now receive until the hearing decision.

☐ **I do not wish to continue to receive** the amount of assistance and/or food stamps I now receive until the hearing decision.

If the hearing decision is not in my favor, I understand that I must repay any assistance and/or food stamps for which I am determined ineligible.

Signature _____ **Date** _____
(Recipient)

SECTION III - STATEMENT OF AGENCY POLICY (to be completed by the Agency Representative)

Date received by Regional or District Office _____

Indicate Specific Manual Reference:

☐ DHS Manual Section_____

☐ Food Stamp Manual Section_____

Explain agency decision in relation to complaint and policy:_____

_____

_____

_____

_____

_____ _____
Signature of Agency Representative **Signature of Supervisor**

_____District Office

AGENCY USE ONLY

Date received in the hearing office_____ **Date of hearing**_____

_____

-OVER-

Introduction and Background

The Aged and Disabled 1915(c) Home and Community Based Waiver (Aged and Disabled Waiver) was first approved and implemented in 1983. Since that time, thousands of Rhode Islanders have taken advantage of the services and supports that can help them stay in their home environments in lieu of entering nursing facilities. The Rhode Island Department of Human Services (DHS) is responsible for all administrative oversight of this program. Administrative case management functions are performed by DHS Long Term Care Caseworkers.

The services included under the Aged and Disabled Waiver are as follows:

- Homemaker
- Personal Care
- Environmental Modifications
- Specialized Equipment
- Meals on Wheels
- Senior Companion, and
- Personal Emergency Response System

The purpose of this plan is to document how the DHS is meeting its assurances to the Centers for Medicare and Medicaid Services (CMS) for operation of the Aged and Disabled Waiver. The DHS is committed to promoting each individual's right to make decisions in all aspects of their life, and recognizes these choices might sometimes lead to unavoidable risk. The agency's role is to provide sufficient information for individuals to make well-informed choices (intervening only when competency to make decisions is of concern), assuring services are provided in a competent manner, and assuring eligibility, need, and cost neutrality for services delivered.

Waiver Roles, Responsibilities and Assurances

The Aged and Disabled Waiver roles and responsibilities are service specific. The Waiver Document (Appendix I) includes a chart that itemizes the licensure and regulatory requirements of each service component. A brief description of each of these service component roles and responsibilities follows:

Homemaker and Personal Care: Must be provided by a licensed Home Care or Home Nursing Care Provider. Rhode Island Department of Health (DOH) licensure requirements and monitoring standards are located in Appendix II. The DHS Case Manager authorizes Homemaker and Personal Care services on an individual basis. In addition to basic licensure requirements, DHS has an enhanced reimbursement program. The enhanced reimbursement gives financial incentive to agencies that provide extra training to staff, accept high acuity clients, provide services on evenings, weekends and holidays, demonstrate client satisfaction, continuity of care and worker satisfaction, and who meet either JCAHO or a state agency accreditation. Details on this program are found in Appendix III.

Environmental Modifications and Specialized Equipment: Must be provided by a Medicare certified entity if for a Medicare covered service not otherwise available under the State Plan. Otherwise, a vendor licensed to do business in Rhode Island must provide these items. These items are prior-approved by the Center for Adult Health Contracting and Payments Unit on an individual basis. The DHS requests individual assessments for modifications and equipment from Independent Living Centers when there is a question about suitability or necessity (policy in Appendix IV).

Meals on Wheels: These are provided by the non-profit organization certified by the Rhode Island Department of Elderly Affairs (DEA).

Senior Companion: The DEA also trains and certifies volunteers to become senior companions. These volunteers are paid a small stipend that is reimbursed under the Aged and Disabled Waiver. DEA maintains records pertaining to the Senior Companion Program.

Personal Emergency Response System (PERS): The DHS Center for Adult Health Contracting and Payments Unit prior approves PERS for individuals and certifies providers of this service. Certification standards are located in Appendix IV.

The following chart (Chart One) summarizes the Aged and Disabled Waiver roles, responsibilities, and location of documentation.

Chart One
Aged and Disabled Waiver Service Summary

Component	Waiver Description	Waiver Requirements Specified	Provider Licensure/Certification	Records Maintained
Homemaker	General household activities provided by trained homemaker, when individual normally responsible is temporarily absent or unable to manage the home and care for him/herself	As per state law	Home Care/Home Health Agency per DOH DHS Enhanced Reimbursement	DOH DHS CAH
Personal Care	Assistance with ADLs that can include meal preparation and housekeeping chores if they are incidental to the personal care being provided, or if essential for health and safety of the individual	Not paid if provided by family member, and must be supervised by RN	Home Care/Home Health Agency per DOH DHS Enhanced Reimbursement	DOH DHS CAH
Environmental Modifications	Physical adaptations to the home specified in POC that are necessary to ensure health, welfare and safety or enable person to function with greater independence in the home and without which the person would require institutionalization	Applicable state or local building codes	Medicare Certified (if Medicare covered)	CAH Contracting & Payments
Special Equipment	Devices, controls or appliances specified in POC which enable an increase in ability to perform ADLs, or to perceive, control, or communicate with the environment in which they live	Applicable standards of manufacture, design and installation	Medicare Certified (if Medicare covered)	CAH Contracting and Payments
Meals on Wheels	Delivery of hot meals to homebound		DEA	DEA

	elderly			
Component	**Waiver Description**	**Waiver Requirements**	**Provider Licensure/Certification**	**Records Maintained**
Senior Companion	Friendship & support to homebound elderly	Volunteers with $3.00 per hour stipend	DEA	DEA
Emergency Response	Limited to people who live alone, or who are alone for significant portions of the day and would otherwise require extensive supervision		Certification enforced by CAH Contracting and Payments Unit	CAH Contracting and Payments
Eligibility/Re-Certifications of Eligibility	Categorically Eligible only with institutional income and resource rules	Annual by DHS Caseworker	N/A	LTC
Level of Care	Nursing Facility	Annual by DHS RN	N/A	CAH OMR/LTC
Plan of Care	Describes services to be furnished, their frequency and type of provider. FFP can only be claimed for waiver services included in the plan of care (see attachment)	Annual by DHS Caseworker	N/A	LTC
Budget Neutrality	Aggregate	Annual by CAH	N/A	CAH
Freedom of Choice	Choice of institutional or community-based care	Only at intake to waiver	N/A	LTC

The assurances that DHS has given to CMS regarding the waiver are addressed on an ongoing basis in a variety of means described below. In addition, DHS oversees effectiveness of ongoing processes through a monthly sampling protocol (described in the following section).

Health and Safety Assurance: The DHS utilizes several ongoing means to assure health and safety of clients. The primary means of monitoring individual health and safety on an ongoing basis is through the home health agencies. These agencies have the most intensive ongoing contact with clients, and are bound by licensure standards to address health and safety concerns (see Appendix II). Agencies are surveyed by the DOH on an approximate yearly basis, with more frequent reviews if problems are identified. The DOH also investigates complaints about licensed agencies.

The DHS Case Manager also plays a significant role in the client's health and safety. The case manager conducts annual assessments, informs clients of waiver options so they can make informed choices, develops the plan of care, and works with the client to resolve problems regarding waiver services. The case manager is usually the person who takes calls from the client.

The CAH OMR reviews each person on at least an annual basis to make a level of care determination. They often request supporting documentation from home health agencies and other sources, and will consult with the case managers and/or the home health agency if there appears to be a problem with appropriateness of care. The Service Utilization Review Team within the DHS fiscal agent EDS also reviews service appropriateness from a provider perspective for all Medicaid services on an ongoing basis (Appendix V).

Abuse, neglect and exploitation are addressed in several ways. The Long Term Care Ombudsman Program investigates and follows through on individual or agency complaints for any of the waivers. The DEA oversees an Elder Abuse and Neglect Program that provides intervention for seniors. In addition, the Department of Mental Health, Retardation and Hospitals (MHRH) will intervene on behalf of people with mental illness or developmental disabilities. The DHS case manager can refer people to any of these programs on an as-needed basis. People at high risk of neglect can also be referred for guardianship/competency proceedings.

Plans of Care Responsive to Needs: The method by which the LTC Case Manager develops the plan of care is outlined in the Aged and Disabled Waiver (Appendix I). The Case Manager conducts an assessment and develops the care plan in conjunction with the client and/or family member as appropriate.

Qualified Providers: The provider enrollment process through the DHS fiscal agent EDS, requires copies of current licensure and approval by CAH staff. Only those providers who meet initial qualifications are able to bill for services. The DOH communicates loss of licensure with DHS so providers can be terminated.

Level of Care Determinations Consistent with Institutional Criteria: The CAH OMR (Registered Nurses) conduct both nursing facility admission screens and waiver level of care determinations. The level of care determinations are repeated on at least an annual basis.

Financial Assurances: All waiver claim payments are made through the Medicaid Management Information System (MMIS). The DHS MMIS system has edits in place that prevent payment for services to people who are not qualified for the waiver. On an annual basis, Program Staff of the CAH evaluate the waiver program for cost neutrality, and report the findings to CMS.

A summary chart (Chart Two) of assurances, ongoing means to address them, and the oversight method(s) follows.

Chart Two (a)
QA System for Assuring Health and Safety – Participant
Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
a. Waiver participant feedback & input	Intake POC development CAC **Agency Care Plan** **Calls to LTC**	LTC LTC CAH HH Agency LTC	Monthly survey	LTC Case Manager
b. Identifying, addressing, and preventing abuse, neglect & exploitation	Home visits/LTC Calls Calls to OMR DEA Elder Abuse Program Alliance for Better LTC MHRH – DD & SPMI DOH Regulation	LTC OMR DEA Alliance MHRH DOH	Risk assessment on monthly sample Protocol for Referral	CAH OMR DHS Legal Department
c. Identify, address & prevent problems with participant access to waiver services	LTC Calls Home Health Enhancements **e HCBS Workgroup** **ance for Better LTC**	LTC CAH DEA Alliance	Monthly sample Quarterly Review	LTC Case Manager Oversight Team
d. Identify, address, & prevent discrepancies between POC and services received	Post payment review/SUR **LTC Calls**	CAH/EDS LTC	MMIS/ InRhodes data analysis on monthly sample	CAH Analysis LTC resolution of discrepancy

Chart Two (b)
QA System for Assuring Participant Health and Safety - Provider
Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
e. Dissemination of Medicaid & waiver-specific requirements to all waiver providers	Inservices/Training LTC Calls EDS Provider Reps Web Site	CAH/LTC LTC EDS CAH	Monthly Sample	CAH Program Staff
f. Contingency plan for emergencies & backup coverage for high risk people without other resources	DOH licensure LTC Calls **LTC Procedures** (> 1 agency high risk)	DOH LTC LTC	Monthly Survey	CAH OMR
g. Provider QA activities are conducted in accordance with provider agreements and means to address non-compliance	Provider Agreement Home health enhancements	EDS CAH	Monthly Survey Quarterly Review	CAH OMR Oversight Team

Chart Two (c)

System for Developing, Approving, & Monitoring Plans of Care
Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
a. Description of POC development and approval process	Waiver document	LTC CAH	N/A	N/A
b. Description of person responsible for POC dev't & approval	Waiver document	LTC CAH	N/A	N/A
c. Assessing if participant has input into POC & whether preferences are considered	N/A	N/A	Monthly sample	LTC Case Manager
d. Do participants have freedom of choice between waiver & institution?	Signed form at intake	LTC	Monthly survey	LTC Supervisor
e. Frequency of POC	Waiver Document **InRhodes**	LTC CAH LTC	Monthly survey	LTC Supervisor

Chart Two (d)

System for Developing, Approving, & Monitoring Plans of Care
Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
f. Documentation of POC approval	InRhodes CP-5	LTC	Monthly survey	LTC Supervisor
g. Assessing whether POC addresses all needs	Client Assessment	LTC	Monthly survey	CAH Program and OMR
h. Are all POC goals addressed by waiver services and/ or other means?	Client Assessment	LTC	Monthly survey	CAH Program and OMR
i. Are POCs revised when participant needs change?	Client Assessment HH Agency Notification to LTC	LTC HH Agency	Monthly survey	CAH Program and OMR

Chart Two (e)
System for Assuring Waiver Services Provided by Qualified Providers
Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
a. Licensing, certification, & other standards for each provider type	Waiver document Provider Enrollment HH Enhancements	CAH EDS CAH		
b. Process for enrolling providers not licensed or certified	PERS Standards Home Mod/Equip Program	CAH		
c. Ongoing monitoring of non-licensed providers	PERS Standards Home Mod/Equip Senior Companion Meals on Wheels	CAH Contracting CAH Contracting DEA DEA	Monthly survey	CAH Program and OMR
d. Assuring waiver providers meet provider standards (who, how and frequency)	Provider enrollment Service Utilization Review Also, see c. above	CAH, EDS EDS SURS		
e. How verification of provider requirements are documented	DHS CAH	CAH, EDS CAH Contracting CAH		
f. Protocols for identifying & addressing where providers do not meet qualifications	Provider Enrollment Process	EDS		
g. Verifying that provider training conducted in accordance with state requirements and the waiver	DOH Surveys HH Enhancements	DOH CAH		

Chart Two (f)

Use of Processes/Instruments for Determining Level of Care
Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
a. Individual evaluation of LOC for each applicant with reasonable indication of need for services in near future but for waiver	LTC assessment & CP-1 sent to OMR for LOC determination	OMR LTC	Monthly Survey	CAH OMR
b. Uses processes & instruments described in waiver	CP-1 Policy Manual	OMR LTC	Monthly Survey	LTC Supervisor CAH OMR
c. Individual re-evaluation at least annually and documented in chart	Waiver document Policy Manual	LTC	Monthly Survey	LTC Supervisor
d. Persons performing LOCs are the same ones identified in waiver	Waiver document	OMR	Monthly Survey	CAH OMR
e. LOCs monitored to be sure of accuracy, & takes action to prevent future errors	Performed by same RNs who approve NF admissions	OMR	Monthly Survey	CAH OMR

Chart Two (g)
State Administrative Authority Over the Waiver
Required Design Features – A&D Waiver

Responsibility for Due Process: LTC

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
a. If other agency has administrative responsibility, show that State Medicaid agency retains authority	N/A			
b. State provides due process in handling requests for waiver services (clients informed at application that they can appeal a negative finding)	On DHS-2	LTC	Monthly Survey	LTC Supervisor
c. State demonstrates that it follows due process in operation of waiver through written notification	InRhodes notices	LTC		

Chart Two (h)

State Financial Accountability

Required Design Features – A&D Waiver

Design Element	Ongoing Method	Responsible Party	Oversight	Responsible Party
a. Policies and procedures on maintaining financial records	Provider agreements MMIS	CAH EDS		
b. Nature and frequency of audits	Auditor General SURS	AG CAH/EDS	Monthly MMIS analysis compared to authorizations	CAH Program
c. Actions taken if problems identified	Recoupment Referral to fraud unit	CAH/EDS CAH		

Monthly Sampling Procedures

The means by which DHS will monitor the Aged and Disabled Waiver services and assurances is through a monthly sampling protocol. The monthly sampling will detect problems on both an individual and system level. The protocols were developed by an Oversight and Monitoring Team comprised of CAH Program and Medical staff, and Long Term Care supervisory staff. The *HCFA Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs* issued December 20, 2000 was used as the basis for the DHS monthly survey protocol.

The monthly survey will include one person selected from those showing the highest possible modified MDS for Home Care Cognition score (indicating possible risk factor from inability to realize consequences of decisions). Another person will be selected from a listing of those authorized more than thirty hours of home health services each week (indicating possible risk factor as a result of impairment causing such a high need for services). The remaining three persons will be drawn randomly from the waiver population. Due to available resources and the time needed to conduct the surveys, each candidate will be selected from a different Long Term Care Office/Record Location. The procedures, worksheets and compilation document follow:

Exhibit One
Procedures for Monthly Surveys

Sample Selection**:** The Program Staff of the Center for Adult Health (CAH) will be responsible for selecting the monthly sample of people meeting the following criteria:

1. One person with the maximum score on the modified MDS for Home Care section on cognitive functioning
2. One person from a different record location who has home health service utilization above thirty hours per week
3. Three persons (each from a different record location) selected at random

The record review and client visit worksheets will be sent with a six month MMIS claims summary on each person to the appropriate Long Term Care Supervisor.

Record Review**:** The long term care supervisor will review the client record and write down the most recent date of each form. Although it is expected that anything overdue will be completed, the written dates should show what was in the record when first reviewed. The completed record review worksheet, DHS assessment, DHS plan of care, and home health agency care plan and nursing assessment (if available) should be sent back to the Program Staff person in the CAH. The CAH Program Staff person will request the home health agency records if they are not already in the LTC client record.

Client Visit and Interview**:** The LTC Case Manager will do a home visit and complete the interview sheet, including reasons for hospitalizations or emergency room visits. The interview sheet will be returned to the CAH Program Staff for compilation.

Financial/Utilization Review**:** The CAH Program Staff is responsible for matching authorization and claim payment information on each sampled client. Any claims for trauma or accidents in the six months ending two months prior to survey month will also be pulled on each of the clients. The CAH Program Staff person will enter this information.

Risk Assessment**:** The CAH Office of Medical Review (OMR) will be given copies of the home health agency and DHS assessments and care plans, client visit results, and summary of claims. They will assess the risk and make recommendations. The CAH OMR will make a direct referral in an emergency situation, but will otherwise refer back to the case manager for follow-up.

Compilation and Dissemination**:** The CAH Program Staff will compile all results and return a person specific summary to each person who participated in the monthly survey (LTC supervisor, CAH Program and OMR Staff), the LTC Senior Casework Supervisor, and the CAH and LTC Administrators.

Aged and Disabled Waiver Oversight and Monitoring
Case Record Review – LTC Supervisor
Worksheet

Client Name: _____ MID _____

Person Completing Review: _____ Date: _____

Form	Most Recent Date
1. DHS 2 or LTC Re-certification	_____
2. CP-1 (Level of Care) or MA 510	_____
3. CP-5 (Plan of Care)	_____
4. PRO Panel	_____
5. Signed CP-12 (Freedom of Choice)	_____
6. DHS Assessment	_____

Please send or fax (462-6339) this form completed with a copy of the most recent CP-5, DHS assessment, home health agency assessment and care plan to Dianne Kayala. Thank you.

Aged and Disabled Waiver Oversight and Monitoring
Financial/Utilization Review – CAH Program Staff
Worksheet

Client Name: _____ MID _____

Person Completing Review: _____ Date: _____

1. Difference between home health hours paid, PRO panel and/or CP-5 past six months:

_____ Agency(ies) _____

Recoupment needed? _____ Detail: _____

2. Are there any other paid waiver claim discrepancies with the CP-5? _____

Detail: _____

3. List quantity of waiver claims paid, six month sample or attach copy of claims

Type of Service	Hour Units
Homemaker	_____
Combination	_____
Personal Care	_____
Meals on Wheels	_____
PERS	_____
Senior Companion	_____

Special Equipment (list)_____

Minor Home Modifications (list) _____

4. List any claims for falls/accidents _____

_____

Aged and Disabled Waiver Oversight and Monitoring
Client Visit – LTC Case Manager
Worksheet

Client Name: _____ MID _____

Person Completing Review: _____ Date: _____

1. In general, do the home services help you?
   Why or why not?

2. Did you take part in deciding the types of services you needed?

3. Do you know how to reach your home health agency?

5. What do you do if your home health worker does not show up for a shift?

6. How would you get help in an emergency?

7. Do you have family or friends who will help you out?
   How often do they help (daily, weekly, monthly, rarely)

8. Do you have any concerns about your safety or well-being?
   Describe if yes

9. Do you know how to reach your case manager?

Case Manager only: Discuss the claims summary of this client with the client. Please list the client's reasons for any hospitalizations, emergency room visits or other high use medical services.

Please describe any concerns you have about the client based on this visit and/or previous experience. Include any concerns about the client's home environment, adaptive equipment needs, etc.

Please send or fax (462-6339) this form back to Dianne Kayala.

Aged and Disabled Waiver Oversight and Monitoring
Risk Assessment – CAH Office of Medical Review
Worksheet

Client Name: _____ MID _____

Person Completing Review: _____ Date: _____

1. Based on claims and home visit, do you consider this person to be at risk of harm? If so, why?

2. Do the home health agency and DHS care plans adequately address risk factors?

   Why or why not?

3. What are your recommendations for this client?

Skilled Home Health Services (Nursing/Rehabilitation) _____
Evaluation for adaptive equipment/home modifications _____
Alzheimer's Home Safety Evaluation _____
Multiple Home Health Agencies for back-up _____
DEA Neglect/Abuse Program Referral _____
Adult Competency/Guardianship Evaluation _____

Other:

Monthly Summary

Selection	Selection	Selection	Record Review	Record Review	Record Review	Record Review	Record Review	Record Review
Name	MID	Month of Review	DHS 2 or LTC Recert (within 1 year)	CP-1/MA-510 (within 1 year)	CP-5 (within 1 year)	PRO Panel (within 1 year)	CP-12 (signed or documented refusal)	DHS Assessment (within 1 year)

Monthly Summary

Record/MMIS Comparison	Record/MMIS Comparison	Record/MMIS Comparison	Client Survey	Client Survey	Client Survey	Client Survey
Does CP-5/ProPanel match HH Claims past 6 months?	Amount of discrepancy (+/-)	Does CP-5 match other waiver claims?	Did client/family have input into POC?	Does client/family know how to get help?	Does client/family know case manager/LTC office	Are there current needs (related to waiver) not being met?

Monthly Summary

Client Survey	Client Survey	Client Survey	Risk Factors	Risk Factors	Risk Factors
Is there family support/home safety?	Does client have PERS/use of telephone & know how to get help?	Appropriate home mods/equipment for safety?	Claims for falls/accidents in past 12 months?	Is client currently at risk?	Agency care plan past 12 months addresses risk factors?

Quarterly Team Review: Every quarter, the Oversight and Monitoring Committee will meet to review all findings from the previous quarter (with identifying information removed). The purpose of this review is to:

- Identify and address pervasive problems (those that occur more than 50% of the time)
- Develop system change recommendations as indicated
- Review oversight system and update and/or change as indicated

The Oversight and Monitoring Committee is comprised of:

- CAH Administrator
- CAH Program Staff
- CAH OMR Staff
- LTC Administrator
- LTC Senior Casework Supervisor
- Cranston LTC Supervisor